State of Tennessee Department of Health

Medical Laboratory Board

227 French Landing, Suite 300 Heritage Place MetroCenter Nashville, TN 37243 (615) 532-3202 1-800-778-4123 Ext. 2-5128 tennessee.gov/health



Medical Laboratory Board PROCEDURES FOR APPLICATION AND LICENSURE

TABLE OF CONTENTS

I.	Application Procedures	Page
	Fees	3
	Application Acknowledgement	3
	Converting Quarter Hours to Semester Hours	3
	Converting CEUs to Clock Hours	3
	Converting Semester Hours to Clock Hours	3
II.	Trainee Permits	
	Registration of the Laboratory Trainee	3
III.	Licensure Information	
	Temporary License	4
	Renewals	4
	Retirement/Reactivation of License	4
	Change of Name or Address	4
	Verification of License	4
	Criminal Background Checks	4
IV.	Requirements	
	General Requirements	5
	Out-of-State Trained Applicants	5
	Internationally Trained Applicants	5-6
	Military Trained Applicants	6
	New Emerging Technology Applicants	7
v.	<u>Checklists</u>	
	Laboratory Director, Director Level Credentialing Agencies	
	Accepted by the Tennessee Medical Laboratory Board	7-9
	Laboratory Supervisor	10
	Documentation Information	11
	Management C.E. Subject Areas for Supervisor Licensure	12
	Cytology General Supervisor	13
	Medical Laboratory Technologist	14-18
	Special Analyst	16-18
	Medical Laboratory Technician	19
	Cytotechnologist	20-21
	Application/Clearance Form/Attachments	
	Medical Laboratory Licensure Application	22-27
	Clearance Form From Other State Licensure Boards	28
	Attachment 1 – Transcript Request	29
	Attachment 2 – Training Program Accreditation	30
	Attachment 3 – National Certification Verification	31

I. APPLICATION PROCEDURES

Fees (Rule 1200-6-1-.06)

The following fees are required for licensure:

\$ 50 (application fee) - nonrefundable \$ 10 (regulatory fee) - nonrefundable \$ 60 TOTAL

Checks or money orders must be made to the State of Tennessee.

Application Acknowledgment

A postcard was enclosed in your application packet. If you return the postcard with your application and it is addressed and stamped, the postcard will be returned upon receipt of your application. **The postcard will not be returned unless the applicant affixes the proper postage to the card.**

Converting Quarter Hours to Semester Hours:

 $\frac{\text{Total Quarter Hours}}{3} \times 2 = \text{Total Semester Hours}$

Converting CEUs to Clock Hours:

Total CEUs x 10 = Total Clock Hours

Converting Semester Hours to Clock Hours:

Total Semester Hours x 15 = Total Clock Hours

II. TRAINEE PERMITS (1200-6-1-.14)

Registration of the Laboratory Trainee

A qualified laboratory trainee shall register at no cost. Registration is valid for a period of two (2) years or less. Each trainee must submit a trainee application when he/she begins his/her practical training in a medical laboratory. **The trainee work permit is only valid in the facility(ies) approved for practice training.** The facility(ies) must be approved prior to internship. A trainee may work in a department after completion of the classroom requirements, along with the clinical rotation period for that department, provided he/she is under the direct supervision of licensed medical laboratory personnel at the technologist level or higher. Documentation that the trainee has demonstrated acceptable competence levels in all procedures routinely performed in that clinical area must become part of that trainee's file.

The trainee permit shall be on file in the training program location and on-site during each clinical training program rotation.

III. LICENSURE INFORMATION

Temporary License (Rule 1200-6-1-.13)

A temporary license may be issued by the Board for an applicant who has successfully completed the academic work, clinical training, and all Board designated requirements for the license sought, and is scheduled to take the next available Board approved examination. Individuals working with this temporary license may work under the supervision of a licensed laboratory professional at the supervisory level or a preceptor assigned by the laboratory supervisor. The preceptor will hold a license equal to or higher than the temporary licensee's level of licensure.

If the applicant fails the examination, the temporary license shall remain valid only until the results of the examination are available to the Board.

Renewals (Rule 1200-6-1-.09)

Licenses are renewed every other year based on the licensee's birthday. A penalty fee is due if your renewal is postmarked past the deadline. The licensee is responsible for notifying the administrative office in writing when there is an address or name change. (See Continuing Education Information, page 8)

Retirement/Reactivation of License (Rule 1200-6-1-.11)

A licensee who holds a current license and does not intend to practice as a medical laboratory professional in Tennessee may retire his/her license. The licensee must complete the Affidavit of Retirement from Practice in Tennessee Form and have it notarized. The licensee will be notified in writing about any change of status of his/her license. Renewal fees will not be required until the license is reactivated. The completion of the reactivation form and approval by the administrative office will allow the licensee to return to work. This document may be obtained from the Board's administrative office or from the Board's internet page indexed as Forms and Applications.

Change of Name or Address (Rule 1200-6-1-.17)

A change in name or address requires **prompt** notification to the Administrative office. You may fax this information to the Administrative office: 615-741-7698.

Verification of License Status

The status of an individual's license is a matter of public record. Anyone inquiring about an individual's license will be given the licensure category, date of certification and if licensee is in good standing. This information may be obtained through the Tennessee Department of Health automated phone system, (615) 532-3202 (local), and following each prompt. Licensure information is also available from the Department's website, www.tennessee/gov, by going to the search engine and typing TN Department of Health-medical laboratory board then click on that selection to reach the Board's homepage.

Criminal Background Check (Rule 1200-6-3-1.05 (m))

Effective June 1, 2006 applicants for **initial** licensure in Tennessee (not applicable to the renewal or reinstatement or upgrade) **must** obtain a criminal background check. This rule affects all individuals required by statute to be licensed by the Tennessee Medical Laboratory Board to include: Technologists, Technicians, Cytologists, Special Analysts and Directors. Please refer to Board's website under the category of Noteworthy for further information: www.tennessee/gov; go to the search engine and type TN Department of Health-Medical Laboratory Board, click on that selection to reach the Board's homepage.

IV.

General Requirements- Mandatory

ALL APPLICANTS

 Completed application
 Notarized application
Complete fees

Completed application

___ Complete fees

Photograph (signed on back of photo, passport size)

Official transcript which indicates that a degree was conferred. (sent directly from the University to this administrative office) See Attachment 1.

__ Graduation from a formal laboratory training program (NAACLS, CAHEA, CAAHEP)

See Attachment 2.

Proof of National Certification (sent directly from the agency or its designee).

See Attachment 3.

___ Completed Criminal Background Check

___ Completed Practitioner Profile

NOTE: All photocopies that are submitted must be notarized as true copies.

Out-of-State Trained Applicants

Must submit a letter of completion from their laboratory training program in addition to the preceding requirements. This letter must be sent directly from the Program Director to the Board's administrative office.

Internationally Trained Applicants (Rule 1200-6-1.05(2))

An **evaluation of a foreign transcript** is required to determine the applicant's eligibility in addition to the general requirements. The evaluation must be obtained from one of the following agencies.

Center For Applied Research, Education Evaluators International, Inc.

Evaluation & Education, Inc. P.O. Box 5397

P.O. Box 20348 Los Alamitos, CA 90720 Long Beach, CA 90801 Phone: (562) 431-2187 Phone: (562) 430-1105 Fax: (562) 493-5021

Fax: (562) 430-8215

Email: www.evalcaree@eaerthlink.net

International Consultants of Delaware, Inc.

Josef Silny and Associates, Inc.

Barksdale Professional Center Suite 109

International Education Consultants

 Newark, DE 19711-3258
 P.O. Box 248233

 Phone: (302) 737-8715
 Coral Gables, FL 33124

 Fax: (302) 737-8756
 Phone: (305) 273-1616

 Email: icd@icdel.com
 Fax: (305) 273-1338

Email: info@silny.com

List continued on page 6

Education Credential Evaluators, Inc.

P.O. Box 514070

Milwaukee, WI 53203-3470

Phone: (414) 289-3400 Fax: (414) 289-3411 Email: eval@ece.org

Education International, Inc.

29 Denton Road

Wellesley, MA 02482 Phone: (781) 235-7425 Fax: (781) 235-6831 Email: edint@gis.net

Foreign Academic

Credentials Services, Inc.

P.O. Box 400

Glen Carbon, IL 62034 Phone: (618) 656-5291 Fax: (618) 656-5292 Email: fasc@aol.com World Education Services, Inc. P. O. Box 745, Old Chelsea Station

New York, NY 10113-0745 Phone: (212) 966-6311 Fax: (212) 739-6100 Email: info@wes.org

Foundation for International Services, Inc.

2150 30th Drive SE, Suite 320

Bothell, WA 98021 Phone: (425) 487-2245 Fax: (425) 487-1989 Email: info@fis-web.com

International Education Research Foundation, Inc.

P. O. Box 3665

Culver City, CA 90231-3665 Phone: (310) 258-9451 Fax: (310) 342-7086 Email: info@ierf.org

The evaluation must be submitted by the evaluating agency. This document must be in the Board's administrative office to determine your eligibility for licensure. The evaluation needs to be a general statement of equivalency. A course by course comparison is not necessary.

All internationally trained applicants must submit a notarized photocopy of their foreign college transcript to the Board's administrative office.

All non-U.S. citizens must submit current documentation of legal entry into the United States. If the documentation is a photocopy of the original, it must be notarized as a true copy.

Military Trained Applicants/Medical Laboratory Technician (Rule 1200-6-1-..22((2)(b)(2)

The applicant must have an associate degree in a laboratory science and successful completion of an official military medical laboratory procedures course of at least fifty (50) weeks duration in residence and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Medical Laboratory Technician). This information will be referenced on form DD214, submitted as a notarized copy of the original. National certification by examination is also required.

Military Trained Applicants/Medical Laboratory Technologist (Rule 1200-6-1-.22 (1) (a (3)

Must have a baccalaureate degree, completion of the fifty (50) week military laboratory training program, three (3) years of full time clinical laboratory work experience as defined in (1)(j) of this rule; the individual must have completed science coursework equivalent to that required in a laboratory science education program as defined by (1)(h) of this rule. The military training program will be referenced on form DD214, submitted as a notarized copy of the original. National certification by examination is required.

New Emerging Technology Applicants (Rule 1200-6-1-.22)

An individual may be issued a special analyst license to perform tests in a limited range (as listed on the license), if the procedure(s) for which licensure is requested is a new, emerging technology in the clinical laboratory or represents a subspecialty not otherwise regulated. The procedure(s) must not be a component of the traditional clinical laboratory science <u>Body of Knowledge</u>.

V. CHECKLISTS

LABORATORY DIRECTOR CHECKLIST (Rule 1200-6-1-.20)

A check or money order in the amount of sixty (\$60) dollars, payable to the State of Tennessee must accompany this form. All applications for director are presented for review and approval by Medical Laboratory Board members during their quarterly meeting.

A pathologist and any other person recognized by the Board as having special qualifications and who is duly licensed and registered to practice medicine in the State of Tennessee will not be required to obtain medical laboratory licensure in addition to his/her medical license. Individuals possessing an earned doctoral degree (non-medical degree) are required to obtain a license as a laboratory director from the Board.

A medical laboratory director must meet one of the following requirements:

Be a physician licensed in Tennessee, certified in clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possess qualifications which are equivalent to those required for such certification (Board eligible).

Meet <u>one of the following</u> requirements to qualify as a director of a laboratory in one or more specialties:

- __ Is a physician licensed in Tennessee, certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, or other boards acceptable to the Board in one or more of the laboratory specialties.
- _ Hold an earned doctoral degree in a chemical, physical, biological or clinical laboratory science, and certified by the American Board of Medical Microbiology, American Board of Clinical Chemistry, American Board of Bioanalysis, American Board of Medical Laboratory Immunology or other certifying boards acceptable to the Board in one or more laboratory specialties.
- Is a physician licensed in Tennessee, who subsequent to graduation has four (4) years or more experience in pulmonary function. The directorship is limited to blood gas analysis (pH, pO₂, pCO₂).
- __ Is a physician licensed in Tennessee, certified by a national board acceptable to the Board (not in traditional laboratory specialty) in the specialty for which approval for directorship is being sought.
- _ Holds an earned doctoral degree and has, in the opinion of the Board, appropriate work experience in a subspecialty for which there is no national certification. These individuals must obtain national boarding in the subspecialty when it becomes available.

Director Level Credentialing Agencies Accepted by the Tennessee Medical Laboratory Board

Medical Doctors, who are duly licensed and registered to practice medicine in the State of Tennessee and are boarded by an acceptable credentialing agency, will not be required to obtain a medical laboratory director's license. Those who hold an earned non-medical doctoral degree are required to obtain a director's license from the Medical Laboratory Board.

I. American Board of Pathology

(813) 286-2444

- A. Anatomical Pathology and Clinical Pathology
 - Qualifies as a Director General Clinical and Anatomical Laboratory
- B. Anatomical Pathology only
 - Qualifies as a Director General Anatomical Laboratory
- C. Clinical Pathology only
 - Qualifies as a Director General Clinical Laboratory
- D. Anatomical Pathology or Oral Pathology
 - MD or Dentist Qualifies as a Director Oral Pathology Laboratory

II. American Board of Bioanalysis

(314) 241-1445

- A. Bioanalyst Clinical Laboratory Director (BCLD)
 - Qualifies as a Director General Clinical Laboratory
- B. High Complexity Clinical Laboratory Director (HCLD)

Qualifies as a Director in the subspecialty in which they are boarded.

Those subspecialties are:

Bacteriology (including mycobacteriology)

Mycology

Parasitology

Virology

Immunology

Hematology (including flow cytometry)

Chemistry (including urinalysis)

Endocrinolgy

Toxicology

Andrology

Embryology

Clinical Molecular Biology

III. American Board of Clinical Chemistry

(202) 835-8727

- A. *Clinical Chemistry*; Qualifies as a Director of Chemistry
- B. *Toxicological Chemistry*; Qualifies as a Director of Toxicology

IV. American Board of Forensic Toxicology Laboratory

(719) 636-1100

Qualifies as a Director of Toxicology Laboratory

V. American Board of Internal Medicine

(215) 446-3500

- A. *Endocrinology*; Qualifies as a Director of Endocrinology
- B. *Hematology*; Qualifies as a Director of Hematology
- C. Gastroentrology; Qualifies as a Director of a Nutrition Laboratory
- D. Infectious Diseases; Qualifies as a Director of an Infectious Disease Laboratory

VI.	American Board of Medical Microbiology Qualifies as a Director of Microbiology	(202) 942-9281
VII.	American Osteopathic Board of Pathology Qualifies as a Director General	(800) 621-1773 ext. 7445
VIII.	American Board of Medical Genetics Clinical Molecular Genetics; Qualifies as a Director of Molecular Diagnostics	

- IX. American Board of Medical Laboratory Immunology
 Director of Immunology and Director of Flow Cytometry
- X. American Board of Histocompatibility and Immunogenetics
 Director of Histocompatibility and Immunogenetics

 ext. 476
- XI. American Board of Pediatrics (919) 929-0461
 A. Infectious Diseases; Qualifies as a Director of a Direct Virology Laboratory
 - B. Gastroenterology; Qualifies as a Director of a Direct Nutrition Laboratory
- XII. American Board of Obstetrics and Gynecology
 Reproductive Endocrinology; Qualifies as a Director of a Direct Nutrition Laboratory
- XIII. American Board of Oral and Maxillofacial Pathology
 Director of Oral and Maxillofacial Pathology Laboratory

 (813)286-2444

MEDICAL LABORATORY DIRECTOR APPLICATION SUMMARY

Gene	ral Requirements-Mandatory
_ _ _ _	Completed application Notarized application Complete fees Photograph (signed on back, passport size) Official transcript which indicates that a degree was conferred. (sent directly from the University to this administrative office) See Attachment 1 Proof of National Boarding (sent directly from the agency to this administrative office) See Attachment 3 Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006 Completed Practitioner Profile
Note:	All photocopies submitted must be notarized as true copies.

LABORATORY SUPERVISOR CHECKLIST (Rule 1200-6-1-.21)

A check or money order in amount of sixty (\$60) dollars, payable to the State of Tennessee must accompany this form.

A laboratory supervisor must meet one of the requirements in Section I and Section II:

SECTION I

Be a physician licensed in Tennessee or possess a doctoral degree with a chemical, physical or biological science as his/her major subject. The applicant must have at least two (2) years of experience in one of the laboratory specialties in a clinical laboratory and with a director at the doctoral level subsequent to graduation.
 Possess a valid general medical laboratory technologist license in Tennessee. Must have at least four (4) years of full time (30 hours per week), clinical laboratory experience, or its equivalent, subsequent to qualifying as a technologist.
 Possess a valid medical laboratory technologist license in Tennessee limited to one of the categories of chemistry, hematology, immunohematology or microbiology. The applicant must have at least four (4) years of full time (30 hours per week), clinical laboratory experience, or its equivalent, subsequent to qualifying as a technologist. The license shall be limited to the category in which the current medical laboratory technologist license is held.
Possess a valid special analyst license in Tennessee limited to one subspecialty and have at least four (4) years of full time (30 hours per week) clinical laboratory experience, or its equivalent, subsequent to qualifying as a technologist. The license shall be limited to the subspecialty in which the current special analyst license is held.

SECTION II

Documentation of sixty (60) clock hours of continuing education to include forty-five (45) clock hours of management and fifteen (15) clock hours of technical courses. At least eight (8) clock hours of management courses must be in a classroom or workshop setting. Please refer to the calculation conversions section to determine eligibility. An individual that qualifies as a medical laboratory director does not have to meet the continuing education requirements.

-Continued on the next page-

DOCUMENTATION INFORMATION

The management courses must either have "management" in their title or be specifically designated or designed for managers or supervisors.

Course documentation may be in the form of diplomas, certificates and letters of verification from employers, professional groups or agencies which conduct the training. All handwritten documents must be signed by the applicant's supervisor(s) to verify attendance.

An official transcript is necessary if the applicant is using college courses for continuing education credit. The transcript must be sent directly from the school to the administrative office of the Medical Laboratory Board.

Work experience must be verified in writing on hospital letterhead. The letters must include: job title, dates of employment and full or part-time employment status. If work experience was part-time, the verification letters must indicate the number of hours worked per week. Work experience letters must be sent directly from the employer to the administrative office of the Medical Laboratory Board.

CONTINUING EDUCATION-ALL LICENSEES

(CANNOT BE USED FOR UPGRADE TO SUPERVISOR)

All individuals in Tennessee, licensed as Medical Laboratory Professionals by the Tennessee Medical Laboratory Board, are required to fulfill twenty-four (24) yours of Board approved Continuing Education (CE) course/requirements during the two (2) calendar year cycle previous to the renewal of the individual's license.

These requirements also pertain to those individuals that have retired their license and wish to reinstate the license, those individuals whose licenses have been revoked, and those individuals whose licenses have expired.

Renewals are based on a two (2) year cycle. Every CE cycle will run from January 1 one calendar year to December 31 of the following calendar year.

For example: January 1, 2006-December 31, 2007 (even year issued licenses) or January 1, 2007 – December 31, 2008 (odd year issued licenses).

Courses accepted and/or sponsored by the Tennessee Medical Laboratory Board may be found on the Board's website, www.tenessee/gov, go to the search engine on that page and type medical laboratory board for a list of this information.

Management Continuing Education Subject Areas For Supervisor License

Adapted from ASCP Board of Registry DLM Certification Subject Materials Approved by Tennessee Medical Laboratory Board

1. Financial Management

Budgets Equipment Acquisition Cost Analysis Financial Accounting

Reimbursement

Materials Management

Contract Negotiation

Billing and Collections

2. **Operations Management**

Quality Assurance/Total Quality Management Licensure Safety Medical-Legal/Risk Management Flow Charting Productivity

3. Personnel Management

Motivation
Staffing
Performance Standards/Evaluation
Counseling/Discipline
Education and Training
Wage and Salary Administration
Conflict Resolution

4. Marketing Management

Product Development Consumer Relations Market Research Managed Care

CYTOLOGY GENERAL SUPERVISOR CHECKLIST (Rule 1200-6-1-.23)

A check or money order in the amount of sixty (\$60) dollars payable to the State of Tennessee must accompany this form.

A cytology general supervisor must meet the following requirements:

Possess a current license as a cytotechnologist from the State of Tennessee.
 Have at least three (3) years of full-time (2080 hours per year) experience as a cytotechnologist within the preceding ten (10) years.

CONTINUING EDUCATION REQUIREMENTS FOR SUPERVISOR-CYTOLOGY

SEE PAGE 8 SECTION II FOR INFORMATION

SUBJECT MATERIALS MUST BE IN CYTOLOGY

Work experience must be verified in writing on hospital letterhead. The letter must include: job title, dates of employment, and full or part-time employment status. If work experience was part-time, the verification letters must indicate the number of hours worked per week. Work experience letters must be sent directly from the employer to the administrative office of the Medical Laboratory Board.

MEDICAL LABORATORY CYTOLOGIST APPLICATION SUMMARY

General Requirements-Mandatory	
Completed application	
Notarized application	
Complete fees	
Photograph (signed on back, passport size)	
Official transcript which indicates that a degree was conferred, if a transcript is	
not on file (sent directly from the University to this administrative office)	
See Attachment 1	
Completion of required continuing education for upgrade to supervisory level	
Do not send originals.	
Verification of work experience	
Completed Criminal Background Check (Only if this is an initial application)	
Completed Practitioner Profile (Updated profile upgrading to supervisory level)	
Note: All copies must be notarized as true copies.	

MEDICAL LABORATORY TECHNOLOGIST CHECKLIST (Rule 1200-6-1.22)

A check or money order in the amount of sixty (\$60) dollars payable to the State of Tennessee must accompany this form.

A medical laboratory technologist shall meet one of the following requirements, in addition to possessing national certification by exam at the technologist level:

- A baccalaureate degree in medical technology or in one of the biological, chemical or physical sciences, and with the completion of a medical laboratory technologist training program.
 A baccalaureate degree, MLT/CLT certification, three (3) years of full time clinical laboratory work experience and completion of science coursework equivalent to that required in a laboratory science education program.
- A baccalaureate degree, completion of the fifty (50) week military laboratory training program, three (3) years of full time clinical laboratory work experience and completion of science coursework equivalent to that required in a laboratory science education program.
- A baccalaureate degree, five (5) years of full time clinical laboratory work experience and completion of science coursework equivalent to that required in a laboratory science education program.
- __ For those individuals obtaining national certification by examination or recognition at the technologist level prior to September 1, 1997:
 - 1. Having received a passing grade on a Health and Human Services proficiency examination in clinical laboratory science and completion of five (5) years of full time clinical laboratory work experience; or
 - 2. A minimum of ninety (90) semester hours including science coursework equivalent to that required in a laboratory science education program and with the completion of a medical laboratory technologist training program that was approved at the time of graduation by National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) or a national accrediting agency acceptable to the Board.

-Continued on the next page-

NOTE: Clinical and core curriculum courses completed in a laboratory training program <u>do</u> <u>not</u> count toward the course hours required in chemistry, biological science or math.

Applicants seeking a categorical technologist license must to refer to the Special Analyst Checklist.

SCIENCE COURSEWORK REQUIRED IN LAB TRAINING PROGRAM

- Sixteen (16) semester hours or twenty-four (24) quarter hours of chemistry which shall include one (1) full academic year of general chemistry courses (including lecture and laboratory) and one (1) course in organic chemistry or biochemistry (including lecture and laboratory). The other courses may be selected from qualitative or quantitative chemistry.
- __ Sixteen (16) semester hours or twenty-four (24) quarter hours of biological sciences, including a course in microbiology (lecture and lab).
- Three (3) semester hours or four and one half (4.5) quarter hours of pre-science mathematics.

Work experience must be verified in writing on hospital letterhead and must be submitted directly from the employer to the administrative office of the Medical Laboratory Board. The letters must include: job title, dates of employment, lab areas of employment and full (30 hours per week) or part-time employment status.

If your work experience was part-time, the verification letters must indicate the number of hours worked per week. Work experience letters must be sent directly from the employer to the administrative office for the Medical Laboratory Board.

MEDICAL TECHNOLOGIST-CATEGORICAL CHECKLIST (Rule 1200-6-1-.22)

	neck or money order in the amount of sixty (\$60) dollars mpany this form.	payable to the State of Tennessee must
A med	edical laboratory technologist may obtain a license limited to	o one of the following categories:
	Chemistry Hematology	Immunohematology Microbiology
The a	applicant must meet the following requirements:	
	Must present proof of national certification by certifying laboratory specialty at which licensure is being sought at national certification as a general technologist.	
	Must meet one of the qualification routes on the medical l	laboratory technologist checklist.
	SPECIAL ANALYST CHECKLIST (Rule 12) An individual may be issued a limited special analyst l limited range (as listed on the license) if the following of	icense to perform tests in only a
_	The individual is certified by a national certification be certification exists, or	ody approved by the Board, where such
_	In the absence of national certification, the individual murelevant to the subspecialty in which licensure is being somanner shall be approved by the Board. Individual continued licensure at the time such certification becomes	ought. All individuals qualifying in this als must obtain national certification for

MEDICAL TECHNOLOGIST GENERALIST OR CATEGORICAL APPLICATION SUMMARY SPECIAL ANALYST APPLICATION SUMMARY

_	Chemistry Hematology	ASCP or NCA or NRCC or AAB or AMT ASCP or NCA or AAB or AMT
_	Immunohematology	ASCP or NCA or AAB or AMT
_	Microbiology Cytogenetics	ASCP or NCA or NRM or AAB or AMT NCA
_	Toxicology	NRCC
_	Histocompatibility\ Immunogenetics	ABHI
	Flow Cytometry	ASCP
_	Andrology	ABB or AAB
_	Embryology	AAB

NOTE: The National Certification Agency or its designee must send a letter of verification of your certification to this administrative office.

DIRECTORY FOR BOARD APPROVED CERTIFYING AGENCIES

The following addresses and phone numbers may aid you in obtaining a verification letter.

American Society for Clinical Pathology (ASCP)

333 West Monroe, Suite 1600

Chicago, IL 60603

Phone: 800-267-2727

Phone: (312) 541-4999 Fax: (312) 541-4498

website: www.ascp.org/bor

American Association for Clinical Chemistry (AACC) American Board of Clinical Chemistry (ABCC)

1850 K Street, NW, Suite 625 Washington, DC 20006-2213 Phone: (202) 832-8287

Fax: (202) 835-4576 website: www.aacc.org

American Society for Microbiology (ASM) National Registry of Microbiologists (NRM)

1752 N Street N.W. Washington, DC 20036 Phone: (202) 737-3600 website: www.asm.org

Medical Technologists American (AMT)

10700 West Higgins Road Park Ridge, IL 60018 Phone: (847) 823-5169

(800) 275-1268 Fax: (847) 823-0458 website: www.amt1.com National Credentialing Agency for Laboratory Personnel, Inc. (NCA)

P.O. Box 15945-289 Lenexa, KS 66285

Phone: (913) 438-5110 ext. 4647

Fax: (913) 599-5340 website: www.nca-info.org

American Society for Histocompatibility & Immunogenetics (ASHI) &

American Board of Histocompatibility (ABHI)

PO Box 19173

Lenexa KS 66285-9173 Phone: (913) 541-0009 Fax: (913) 599-5340

website: www.ashi-hla.org/abhi

American Board of Bioanalysis (ABB)

906 Olive Street, Suite 1200 St. Louis, MO 63101-1434 Phone: (314) 241-1445 Fax: (314) 241-1449 website: www.abb.org

American Association of Bioanalysts (AAB)

906 Olive Street, Suite 1200 St. Louis, MO 63101-1434 Phone: (314) 241-1445 Fax: (314) 241-1449

website: www.aab.org

MEDICAL LABORATORY TECHNICIAN CHECKLIST (Rule 1200-6-1,22)

A check or money order in the amount of sixty (\$60) dollars, payable to the State of Tennessee must accompany this form.

A medical laboratory technician shall meet one of the following requirements, in addition to possessing national certification by exam at the technician level:

	Successful completion of a medical laboratory technician associate degree program.
	An associate degree in a laboratory science and successful completion of an official military medical laboratory procedures course of at least fifty (50) weeks duration in residence and have held the military enlisted occupational specialty of Medical Laboratory Specialist (Medical Laboratory Technician). This information will be referenced on Form DD214, submitted as a notarized copy of the original document.
_	An associate degree in a laboratory science that meets specific science requirements (six (6) semester hours of chemistry and six (6) semester hours of biology) for entrance into a medical laboratory technician training program and three (3) years of full time clinical laboratory work experience.

MEDICAL LABORATORY TECHNICIAN APPLICATION SUMMARY

General Requirements		
	Completed application	
	Notarized application	
	Complete fees	
	Photograph (signed, on back passport-size)	
	Official transcript which indicates that a degree was conferred (sent directly from the University to	
	this administration office) See Attachment 1	
	Graduation from a formal laboratory training program (NAACLS, CAHEA, CAAHEP)	
	See Attachment 2	
	Proof of National Certification (sent directly from the agency or its designee)	
	See Attachment 3	
	Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006	
	Completed Practitioner Profile	
NOT	NOTE: All photocopies that are submitted must be notarized as true copies.	

CYTOTECHNOLOGIST CHECKLIST (Rule 1200-6-1-.24)

A check or money order in the amount sixty (\$60) dollars payable to the State of Tennessee must accompany this form.

A cytotechnologist shall meet one of the following requirements:

- ___ Graduated from a school of cytotechnology accredited by the Committee on Accreditation of Allied Health Education Programs (CAAHEP), the Committee on Allied Health Education and Accreditation (CAHEA) or other accrediting agencies acceptable to the Board.
- Be certified in cytotechnology by a certifying agency approved by the U.S. Department of Health and Human Services (HHS).

NOTE: IF YOU QUALIFY FOR LICENSURE BASED ON NATIONAL CERTIFICATION, YOU MUST HAVE THE CERTIFYING AGENCY SEND PROOF OF YOUR CERTIFICATION DIRECTLY TO THIS OFFICE.

__ Before September 1, 1992 -----

Have successfully completed two (2) years in an accredited institution with at least twelve (12) semester hours in science, eight (8) hours of which are in biology; and

- a) Have had twelve (12) months of training in a school of cytotechnology accredited by an accrediting agency approved by HHS; or
- b) Have received six (6) months of formal training in a school of cytotechnology accredited by an accrediting agency approved by HHS and six (6) months of full-time experience in cytotechnology in a laboratory acceptable to the pathologist who directed the formal six (6) months of training.
- Have achieved a satisfactory grade to qualify as a cytotechnologist in a proficiency examination approved by HHS and designed to qualify persons as cytotechnologists.

-Continued on the next page-

___ Before September 1, 1992 - - - - -

Have full-time experience of at least two (2) years or equivalent within the preceding five (5) years examining slide preparations under the supervision of a physician, and

Before January 1, 1969, must have -

- a) Graduated from high school, and
- b) Completed six (6) months of training in cytotechnology in a laboratory directed by a pathologist or other physician providing cytology services; and
- c) Completed two (2) years of full-time supervised experience in cytotechnology.

SPECIAL ANALYST-CYTOTECHNOLOGIST APPLICATION SUMMARY

General Requirements		
	Completed application	
	Notarized application	
	Complete fees	
	Photograph (signed, on back, passport size)	
	Official transcript which indicates a degree was conferred (sent directly from the University to this	
	administrative office) See Attachment	
	Graduation from a formal laboratory training program (CAAHEP)	
	See Attachment 2	
	Proof of National Certification (sent directly from the agency or its designee)	
	See Attachment 3	
	Completed Criminal Background Check-Initial Applicants Only, Effective June 1, 2006	
	Completed Practitioner Profile	
NOTI	NOTE: All photocopies that are submitted must be notarized as true copies.	

Return completed application form to: Division of Health Related Boards/BHLR Medical Laboratory Board 227 French Landing, Suite 300 Heritage Place, MetroCenter Nashville, TN 37243 **For Office Use Only**

05/001 \$50 Application Fee 05/006 <u>\$10 Regulatory Fee</u> \$60 Total Fee

Payable to: State of Tennessee

APPLY FOR CATEGORY (Check One)

PERSONAL INFORMATION

☐ Director(Specify)	Last Name	First	M.I.	Maiden
□ Supervisor				
☐ Medical Technologist	Address			ort-size
☐ Medical Lab Technician			PHO'Signe	
☐ Special Analyst:	City, State		Signe	u
☐ Chemistry	City, State			
☐ Hematology				
☐ Immunogenetics	Zip Code			
☐ Microbiology	•			
☐ Histocompatibility/Immunogenetics	(H) Phone		(W) P	Phone
☐ Cytotechnology				
☐ Toxicology	Citizenship		Rirth	place (city,
☐ Cytogenetics	_			foreign city)
☐ Flow Cytometry	□U.S.A. □Other	r		
☐ Andrology	Specify	.		
□ Other	Social Security Numb	er	Birth	date
(Specify)			(mo/d	lay/yr)
	Sex (optional)		Race:	(optional)
	☐ Male ☐ Female		□Wh □Oth	ite □Black ier
Have you previously applied for a trainee per	mit? □ Yes □ No			
Name Used:				
Have you previously applied for licensure in t \square Yes \square No	he state of Tennessee fro	om the Medical	Labora	atory Board?
Name Used:	When Applied	l:		

EDUC	ATION	INFOR	MATION

Name and Address of School	Dates	Year of Degree	Type of Degree	Major
	-			
	Name and Address of School	Name and Address of School Dates	Name and Address of School Dates Year of Degree	Name and Address of School Dates Year of Degree Degree Type of Degree

College Credits	Semester Hours	Quarter Hours	Laboratory Training (indicate length)
TOTAL CHEMISTRY			□Clinical Chemistry
General Chemistry			□Hematology
Organic Chemistry			□Immunohematology
Biochemistry			□Microbiology
TOTAL BIOLOGY			□Mycology
Microbiology			
General Biology			□Parasitology
Physiology			□Serology
Comparative Anatomy			□Urinalysis
Histology			□Body Fluids
TOTAL MATH			□Other

LICENSURE INI	FORMATION	
Do you currently have a license from another state? ☐ Ye If yes, which state?	es 🗆 No	
Do you currently have a National Certification? ☐ Yes ☐ If yes, which agency? License #		
Have you applied for National Certification? ☐ Yes ☐ N If yes, which agency? When are you sch		
EMPLOYMENT INFORMATION	(LIST MOST RECEN	T FIRST)
Name and Address of Employer	Job Title	Hours Per Week
	Dates of Employment From	to
Name of Supervisor and Title	List Depart.(s) of your	employment
Description of duties and responsibilities:	1	
Name and Address of Employer	Job Title	Hours Per Week
	Dates of Employment From	to
Name of Supervisor and Title	List Depart.(s) of your	employment
Description of duties and responsibilities:		
Name and Address of Employer	Job Title	Hours Per Week
	Dates of Employment From	
Name of Supervisor and Title	List Depart.(s) of your	employment
Description of duties and responsibilities:	•	

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. <u>In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted with this application.</u>

For the purposes of these questions, the following phrases or words have the following meanings:

- 1. "Ability to practice in the medical laboratory field" is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical decisions and exercise reasoned medical laboratory judgements and to learn and keep abreast of medical laboratory developments; and
 - b. The ability to communicate those judgments and information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform medical laboratory tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- 2. "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning, HIV disease, tuberculosis, drug addition and alcoholism.
- 3. "Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- 4. "Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
- 5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

			YES	NO
1.	•	currently have a medical condition which in any way impairs or limits your o practice in the medical laboratory field with reasonable skill and safety?		
	a.	If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?		
	b.	If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the practice, the setting or the manner in which you have chosen to practice?		

(If you receive such ongoing treatment or participating in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure).

COMPETENCY INFORMATION CONTINUED

QUE	STION	S:	YES	NO
2.	Do you	currently use chemical substances?		
	a.	If yes, do they in any way impair or limit your ability to practice in the medical laboratory field in regard to skill or safety?		
3.	Are yo	u currently engaged in the illegal use of controlled substances?		
	a.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?		
4.		you ever been diagnosed as having or have you ever been treated for iilia, exhibitionism or voyeurism?		
5.	laborat denied,	have ever applied for a license or certificate to practice in the medical ory field in any state, country or providence was or has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, ed or voluntarily surrendered under threat of investigation or disciplinary		
6.	•	you ever applied for and been denied a state or federal controlled ace certificate?		
	a.	If you have possessed such a certificate has it ever been revoked, suspended, restricted or otherwise disciplined or voluntarily surrendered under threat of investigation or disciplinary action?		
7.		ou ever been convicted of a felony or a misdemeanor other than a minor offense?		
8.	In relat	ion to the performance of your professional services in any profession:		
	a. b.	Have you ever had a final judgment rendered <u>against</u> you; or Have you ever had a settlement of any legal action rendered <u>against</u> you; or		
	c.	Are there any legal actions pending <u>against</u> you or to which you are a party?		
9.	ever be	have ever held a license or certificate in any health care profession, has it sen reprimanded, suspended, restricted, revoked, or otherwise disciplined, ed or voluntarily surrendered under threat of investigation or disciplinary		
10.	-	ou ever been dropped, suspended, expelled or disciplined by any school, or training program for any reason?		

APPLICANT: COMPLETE THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT OF APPLICANT APPLICANT'S CONSENT AND RELEASE

In applying for licensure in the State of Tennessee, I HEREBY:

SIGNIFY MY WILLINGNESS to appear to answer such questions as the Board may find necessary and which may include a full Board interview:

AUTHORIZE THE BOARD, its staff and representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

CONSENT TO THE RELEASE of such information;

RELEASE FROM LIABILITY the Board, its staff and representatives for their acts performed and statements made in good faith and without malice in connection with evaluating my application, credentials and qualifications.

RELEASE FROM LIABILITY all organizations which provide information in good faith and without malice concerning my professional competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubt about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

	SIGNATURE	DATE
person referred to is application. He/she regulations which we	n this application, he/sh further swears that he/sh are enclosed in the applica	, being duly sworn and identified as the e attests to the truth of each statement made in said he has read and understands that law and the rules and tion packet and agrees to abide by them while in practice aid instrument by him/her executed, to be his/her free act
NOTARY SEAL		
Sworn to before me,	thisday of	, 20
	My com	nmission expires
NOTARY PUBLIC		
LE/G3010192		



STATE OF TENNESSEE DEPARTMENT OF HEALTH DIVISION OF HEALTH RELATED BOARDS 227 FRENCH LANDING, SUITE 300 HERITAGE PLACE, METROCENTER NASHVILLE, TENNESSEE 37243

TENNESSEE MEDICAL LABORATORY BOARD CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (Copies of this form may be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

инзотнинон. То ехреине убит	application, you	Titay Wisi	1 10 001	maci me appricable sime	(6).
	was granted a li	cense to j	oractice	e	with license
(Name of Applicant)	C	-		(Profession)	
Numberon	·	in th	e State	of	. The Medical
	(Date)				•
Laboratory Board of Tennessee	requests that I	submit ev	idence	of the current status of the	hat license in your
state. You are hereby authorize	•				•
to:	÷			,	• 1
	C4-	. 670			
		te of Teni		•	
		Laborat			
	227 Frenc		·		
	Heritage				
I	Nasn	nville, TN	51245)	
Date:					
	-	Applican	nt's Sig	nature	_
		11		141.02.0	
I					<u> </u>
	Applica	nt's typed	l or pri	nted name	
ADMINISTRATIVE OFFICE	E OF STATE I	ICENSU	JRE B	OARD, PLEASE COM	PLETE:
Name In Full As It Appears On	License:				
License Number					
Basis of issuance: Endorse					su
(Check One)	ment/recipioei	ty with		(State)	
	Examination			· · ·	
				(Name of Exam)	
The license is currently active a	and registered?				
		yes	no		
Is there any derogatory information	tion on file?			_ If yes, an explanation n	nust be attached.
		yes	no		
Authorized Signature		Ti+1	10		

ATTACHMENT 1



STATE OF TENNESSEE DEPARTMENT OF HEALTH DIVISION OF HEALTH RELATED BOARDS 227 FRENCH LANDING, SUITE 300 HERITAGE PLACE, METROCENTER NASHVILLE, TENNESSEE 37243

MEDICAL LABORATORY 1-800-778-4123 EXT. 2-5128 OR (615) 532-5128

APPLICANT: Complete this attachment: MAIL THIS FORM TO YOUR COLLEGE(S).

Year of Graduation:	Social Security Number :	
Student Identification Number: Year of Graduation: Degree Obtained: TO WHOM IT MAY CONCERN: I am applying for a license to practice as a Medic Please forward an original transcript bearing the State of Tennessee Medical Laboratory Board 227 French Landing, Suite 300 Heritage Place, MetroCenter		<u></u>
Degree Obtained: TO WHOM IT MAY CONCERN: I am applying for a license to practice as a Medic Please forward an original transcript bearing the State of Tennessee Medical Laboratory Board 227 French Landing, Suite 300 Heritage Place, MetroCenter		
TO WHOM IT MAY CONCERN: I am applying for a license to practice as a Medic Please forward an original transcript bearing the State of Tennessee Medical Laboratory Board 227 French Landing, Suite 300 Heritage Place, MetroCenter		
I am applying for a license to practice as a Medic Please forward an original transcript bearing the State of Tennessee Medical Laboratory Board 227 French Landing, Suite 300 Heritage Place, MetroCenter		
Medical Laboratory Board 227 French Landing, Suite 300 Heritage Place, MetroCenter	•	ne State of Tennessee
14311viiie, 114 37243		
Applicant's Signature		

ATTACHMENT 2



STATE OF TENNESSEE DEPARTMENT OF HEALTH DIVISION OF HEALTH RELATED BOARDS 227 FRENCH LANDING, SUITE 300 HERITAGE PLACE, METROCENTER NASHVILLE, TENNESSEE 37243

MEDICAL LABORATORY BOARD 1-800-778-4123 EXT. 2-5128 OR (615) 532-5128

APPLICANT: Complete this attachment: MAIL THIS FORM TO YOUR LABORATORY TRAINING PROGRAM DIRECTOR.

FULL NAM	E:(Last)	(First)	(Middle)	(Maiden)
ADDRESS:			Security Number:	, ,
ADDRESS.	- 		Security Number.	
Student Ident	tification Number:	:		
Date of Grad				
To Whom It	May Concern:			
•	gram Director:			
Official Nam Of Training 1	ne and Address Institution:			
<i></i>		-		
Phone number	er:			
	•	the time this student wa	<u> </u>	
Signature of	Program Director		Date	
PH 1056 (Re	ev 09/06)	Page 30 of 31		S 836-1

ATTACHMENT 3

NATIONAL CERTIFICATION VERFICATION

Complete this attachment by type or printing legibly in ink.

MAIL THIS FORM TO THE AGENCY

Certifying Agency Name: And Address:			
	ing agency listed above to release the Tennessee Medical Lace at the address below.	=	-
and certification number to	the Tennessee Medical Lace at the address below.	boratory Board.	Please forward this

Please mail certification verification directly to:

State of Tennessee
Department of Health
Tennessee Medical Laboratory Board
227 French Landing, Suite 300
Heritage Place, MetroCenter
Nashville, TN 37243
1-800-778-4123 Ext. 2-5128 or (615) 532-5128

LE/G3010192/LLS



TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR

LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, et seq., requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license.

A blank copy of the profile questionnaire may be obtained from the following web site address: http://tennessee.gov/health. Then select "Forms and Publications," then "Consumer Right-To-Know," then "Mandatory Practitioner Profile Questionnaire for Licensed Health Care Providers."

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by printing neatly in block letters in ball point pen or by typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place, MetroCenter
Nashville, TN 37243

- Do not return pages 1 through 4 with the questionnaire to the department
- Keep a copy of the questionnaire for your records.

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- <u>License number:</u> Fill in your license number and indicate your profession in the space provided.
- <u>Social security number:</u> Your social security number will <u>not</u> be published or in any way given out to the public. It is required for in-house tracking purposes only.
- <u>Primary Practice Address:</u> Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

PH 3585 (Rev. 09/06) Page 2 RDA S836-1

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. The definition for "hospital" can be found at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If there are more than five (5), please enclose an attachment.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, frauds, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution

- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

- A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below \$75,000 are not required to be submitted.
- B) For Chiropractors, judgments or settlements below \$50,000 are not required to be submitted.
- C) For Dentists, judgments or settlements below \$25,000 are not required to be submitted.
- D) For all other professions, judgments or settlements below \$10,000 are not required to be submitted.

<u>Pending</u> malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name	License #	
Profession		

HEALTHCARE PROVIDER INFORMATION MANAGER TENNESSEE DEPARTMENT OF HEALTH DIVISION OF HEALTH RELATED BOARDS 227 FRENCH LANDING, SUITE 300 HERITAGE PLACE, METROCENTER NASHVILLE, TENNESSEE 37243

I.	PRACTITIONER DATA	
A. B.	PROFESSIONAL LICENSE NUMBER:SOCIAL SECURITY NUMBER:profile or website).	
C.	NAME (INCLUDE MAIDEN AND ON 2 ND /3 RD LINES ANY CURRENT NAME:	ALIASES, IF APPLICABLE):
	(LAST) (FIRST)	(MIDDLE) (IF APPLICABLE)
	FORMER NAME(S):	
	(LAST) (FIRST)	(MIDDLE)
	(LAST) (FIRST)	(MIDDLE)
D.	PRIMARY PRACTICE ADDRESS:	Check here if
	(PRACTICE NAME)	your primary practice address is your home address and
	(STREET NUMBER AND NAME)	you want it to be published as part of the profile and on
E.	(CITY) (STATE) E-MAIL ADDRESS Your e-mail address will be published unless you elect	(ZIP CODE) the web site.
F.	WEB PAGE ADDRESS Your web page address will be published unless you	
G.	TELEPHONE: () Your telephone number will be published unless you	elect not to by checking here.
H.	LANGUAGES, OTHER THAN ENGLISH: Indicate languathat may be available at your primary practice location.	
l.	SUPERVISING PHYSICIAN, If you are required by law assistant or nurse practitioner) indicate the name(s) and you need more space, attach additional sheets: 1	to be supervised by a physician (physician address(es) of each supervising physician. If

Practitioner's Name			_ License #				
Profession							
II.	II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING						
A.	A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))						
	PROGRAM/INSTITUTION		CITY/STATE/ COUNTRY		DATE OF GRADUATION	ı	TYPE OF DEGREE
1.							
2.							
3.							
4.							
5.							
6.							
B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))							
	ROGRAM AND SPECIALTY A (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)		LOCATION OF TRAINING (CITY,STATE,COUNTRY)		FROM MM/DD/YYYY		TO MM/DD/YYYY
1.							
2.							
3.							
4.							

Pract Profe	itioner's Name ession	License #		
III.	SPECIALTY BOARD CERTIFICATIONS:			
-	rou hold a certification, specialty or subspecialty from a board regulating the profession for which you are lid		YES INO I	
(Auth	hority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete se	ction below		
CE	RTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY	//SUBSPECIALTY	
1.				
2.				
3.				
4. 5.				
IV.	FACULTY APPOINTMENTS			
A.	Have you had the responsibility for graduate me (10) years? (Authority: T.C.A. § 63-51-105(a)(YES 🗆 NO 🗅		
B.		ou currently hold a faculty appointment at a medical/health related institution gher learning? (Authority: T.C.A. § 63-51-105(a)(10))		
	If "YES", list the title of the appointment, name((Attach additional sheets, clearly labeled with the			
	TITLE	INSTITUTION	CITY/STATE	
1.				
2.				
3.				
4.				
٧.	STAFF PRIVILEGES			
If "YI	Oo you currently hold staff privileges at a hospital? (Au ES", list each hospital at which you currently have sta stion number, if necessary)	- ',','	YES NO ., clearly labeled with this	
	Name of Hospital	City/State		
1.				
2.				
3.				
4. 5.				
J.				

Practitioner's Name License			ense #		
	Do you currently participate in and accept any Te ES", list each plan in which you currently particip	ate or accept as a provider: (Autho	YES □ NO □ rity: T.C.A. § 63-51-105(a)(16))		
	Nam	ne of TennCare Plan			
1. 2. 3. 4.					
5.					
VII.	FINAL DISCIPLINARY ACTION (See	Instructions):			
A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES □ NO □ If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)					
	ENCY NAME/ADDRESS DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION		
IF "Y 2.	ES", is this final disciplinary action under appeal	? (attach copy of notice of appeal)	YES □ NO □		
IF "Y 3.	ES", is this final disciplinary action under appeal	? (attach copy of notice of appeal)	YES • NO •		
IF"	YES", is this final disciplinary action under appea	al? (attach copy of notice of appeal)	YES □ NO □		

Practitioner's Name Profession	License #
B. Within the previous ten (10) years, have you ever had your hospital preasons related to competence or character by the hospital's governing	
If "YES", list name(s) and address(es) medical institution(s) and a brief des stated reason(s) for the action. (Attach additional sheets, clearly labeled with	
HOSPITAL NAME/ADDRESS DATE DESCRIPTION OF V	/IOLATION DESCRIPTION OF ACTION
IF "YES", is this final disciplinary action under appeal? (attach copy of no	,
IF "YES", is this final disciplinary action under appeal? (attach copy of no. 3.	, ,
IF "YES", is this final disciplinary action under appeal? (attach copy of not competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))	owed to resign from or had any medical staff
If "YES", list name(s) and address(es) of the hospital(s) and a brief desc stated reason(s) for the action. (Attach additional sheets, clearly labeled with	
HOSPITAL NAME/ADDRESS DATE	DESCRIPTION OF ACTION
1	
2.	
If "YES", is this final disciplinary action under appeal? (attach copy of notice of a	ppeal) YES 🗖 NO 🗖
3.	
If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)	ppeal) YES 🗖 NO 🗖

Practitioner's Name Profession		_icense#
VIII. CRIMINAL OFFENSES (See Ir		
Have you within the most recent ten (10) years, guilty or nolo contendere to a criminal misdemean ☐ NO ☐	been found guilty, regardless of whether	adjudication of guilt was withheld, or pled r.C.A. § 63-51-105(a)(1)) YES
If "YES" briefly describe the offense(s):		
DESCRIPTION OF OFFENSE	DATE	JURISDICTION
If "YES", is this final disciplinary action under ap		YES 🗆 NO 🗅
2If "YES", is this final disciplinary action under ap 3.		YES 🗆 NO 🗅
3. If "YES", is this final disciplinary action under ap	peal? (attach copy of notice of appeal)	YES 🗆 NO 🗖
IX. LIABILITY CLAIMS		
Have you had a medical malpractice court junction (Authority: T.C.A. § 63-51-105(a)(5)) If "YES claim report(s), and the amount of the judgment of the judgment of the second sec	s", indicate a brief description of the na	
ENTRY DATE OF DISPOSITION	N ORDER OR SETTLEMENT	AMOUNT
1.		
2. 3.		
A. PUBLICATIONS: List any publications y T.C.A. § 63-51-105(a)(11))	ou have authored in peer-reviewed n	nedical literature: (optional) (Authority:
TITLE	PUBLICATION	DATE
1.	-	
2. 3.	<u>-</u>	
4		
B. PROFESSIONAL OR COMMUNITY SER community service associates, activities a		
COMMUNITY SERVICE/AWARD/	HONOR	ORGANIZATION
1.		
2. 3.		<u> </u>
4.		
I affirm these statements are true and in disciplinary action against my license		13 and/or 63-51-118.
(Signature of Provider)		Date: